the on-coming RN the need to continue the assessment. Initial nursing assessments are completed within 24 hours of admission.

7. Upon transfer from one program/unit to another, or when the length of stay in another facility exceeds 24 hours, a reassessment and review of the Nursing Care Plan (NCP)/Interdisciplinary Treatment Plan is completed within 24 hours of the transfer on the Nursing Assessment form.
8. Pain Assessment Screen (Refer to Pain Assessment, Nursing Service Policy).
9. The Health Care Technician (HCT) may assist in data collection during the assessment process and documents on the Nursing Assessment form.
10. The RN is responsible for immediately reviewing data collected by the HCT and no later than within one hour of arrival to ward. After reviewing, the RNs signature, date, and time is recorded beside the HCT's signature.
11. Problems are entered into the chart by placing the problem statement on the tentative problem list, identified with a T number, dated, and signed. At the time of treatment team, the problems are transferred to the prioritize problem list as appropriate.
12. Ongoing reassessment are documented by the RN on the Multipurpose Flowsheet, Vital Signs/Weight/Glucose Flowsheet, Intake and Output Flowsheet, and the Medication Administration Record (MAR). Also, patients are reassessed by the RN whenever there is a change in the patient's condition.
13. Routine reassessments are documented in the Progress Notes section of the medical record as per frequency defined in Clinical Care Plan policy VI-P-9 "*Progress Notes/Treatment Notes, Frequency and Content*".

Nursing Care Plan

14. A NCP is completed within 24 hours of admission. Review of the Nursing Care Plan occurs at the time of reassessment. The NCP is revised whenever the patient's condition changes.
15. The NCP has specific treatment modalities/interventions aimed at resolving or reducing the severity of the identified nursing problems. Each tentative problem initiated by nursing on the tentative problem list has a NCP.
16. The RN documents in the progress notes when tentative problems are resolved and indicates the resolution on the tentative problem list.
17. NCPs are individualized and based on the patient's identified problems and appropriate interventions.

Interventions

18. Treatment modalities/interventions address what the responsible staff will do, rationale, frequency, and responsible discipline.
19. Treatment modalities/interventions are realistic and stated in positive terms. Action words are used so that interventions are measurable.
20. Treatment Team Progress Notes are completed by RNs, LPNs, and HCTs. Each employee is responsible for documenting care and treatment as outlined in the NCP and Interdisciplinary Treatment Plan.
21. The RN documents implementation of interventions and the patient's response. Documentation is outcome based and specific to identifying progress made towards the goal(s).
22. Nursing Service Personnel (RN and HCT) documents progress notes according to the Clinical Care Plan Policy VI-P-9 "*Progress Notes/Treatment Notes, Frequency and Content*".

Evaluation

23. RNs evaluate treatment outcomes and document in the Treatment Team Progress Notes or the Active Treatment database.
24. Each intervention assigned to Nursing Service personnel is addressed in the Treatment Team Progress Notes.
25. Evaluations by the RN state whether or not there has been progress, regression, or no change regarding accomplishing the patient goals as outlined in the interdisciplinary treatment plan.
26. Evaluations documented in the progress notes are considered during the revisions of the NCP and/or Interdisciplinary Treatment Plan.

Related Policies: CCP: VI-P-9 Progress Notes/Treatment Notes, Frequency and Content
CCP: VI-T-2 Transfer of Patients
CCP: VI-T-4 Treatment Planning

Attachments: None

Section V N-1
Effective 8/20/08 — Deleted: 7-07-2008
Supercedes 7/07/08 — Deleted: 3-04

Subject: Nursing Process

Purpose: The Psychiatric-Mental Health Nurse collects patient health data, analyzes the assessment data in determining nursing diagnoses and develops a plan of care that prescribes interventions to attain expected outcomes. To provide a consistent format for Nursing Service Personnel to assess, plan, implement, and evaluate quality patient care.

Authority:
N.C. Nurse Practice Act, July 2007
ANA Scope & Standards of Practice, 2004
Scope & Standards of Practice for Psychiatric Mental Health Nursing, 2007
Joint Commission Standards PC.2.120, PC.2.130, & PC.2.150
CMS Standards §482.23 (b)(4)
DHSR Standards §.3804
21 NC Administrative Code 36.0224
21 NC Administrative Code 36.0225

Standard: The roles and responsibilities of Nursing Service staff are identified. The assessment, planning, documentation, and evaluation of patient outcomes are established and serve as a guide to Nursing Service Personnel.

Policy:

1. The nursing process is evident in the individual nurse's performance in the care and treatment of patients. — Deleted: Nursing process shall be
2. Registered Nurses (RNs) are accountable for assessing each individual patient's needs and for planning, implementing, and evaluating the treatment plan. — Deleted: shall be
3. The RN assesses all patients' status at the beginning of each shift. This process involves hand-off communication, ward report, and patient rounds during the shift. — Deleted: shall assess
4. There is a nursing component of each patient's interdisciplinary treatment plan. The plan includes nursing strategies directed towards the treatment plan problems and goals. This component of the plan is monitored and evaluated by a RN with recommendations for changes documented on the treatment team progress notes and discussed with the treatment team. — Deleted: shall be; Deleted: shall; Deleted: shall be

Assessment

5. A pre-admission assessment is completed in the Admission's Office prior to the patient going to the ward. — Deleted: will be; Deleted: a
6. A nursing assessment is initiated by the admitting RN on each patient on the shift the patient is admitted. The nursing assessment is documented on the Nursing Assessment form. In the event the nursing assessment cannot be completed within the admitting shift due to the patient's condition/refusal, the RN documents such in the progress notes. The RN shall communicates via the ward written report and verbally to the on-coming RN the need to continue the assessment. Initial nursing assessments are completed with 24 hours of admission. — Deleted: o; Deleted: shall be; Deleted: in all psychiatric admission units; Deleted: shall be; Deleted: shall

7. Upon transfer from one program/unit to another, or when the length of stay in another facility exceeds 24 hours, a reassessment and review of the Nursing Care Plan(NCP)/Interdisciplinary Treatment Plan is completed within 24 hours of the transfer on the Nursing Assessment form.
8. Pain Assessment Screen (Refer to Pain Assessment, Nursing Service Policy).
9. The Health Care Technician (HCT) may assist in data collection during the assessment process and documents on the Nursing Assessment form.
10. The RN is responsible for immediately reviewing data collected by the HCT and no later than within one hour of arrival to ward. After reviewing, the RNs signature, date, and time is recorded beside the HCT's signature.
11. Problems are entered into the chart by placing the problem statement on the tentative problem list, identified with a T number, dated, and signed. At the time of treatment team, the problems are transferred to the prioritize problem list as appropriate.
12. Ongoing reassessment are documented by the RN on the Multipurpose Flowsheet, Vital Signs/Weight/Glucose Flowsheet, Intake and Output Flowsheet, and the Medication Administration Record (MAR). Also, patients are reassessed by the RN whenever there is a change in the patient's condition.
13. Routine reassessments are documented in the Progress Notes section of the medical record as per frequency defined in Clinical Care Plan policy VI-P-9 "*Progress Notes/Treatment Notes, Frequency and Content*".

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Nursing Care Plan

14. A NCP is completed within 24 hours of admission. Review of the Nursing Care Plan occurs at the time of reassessment. The NCP is revised whenever the patient's condition changes.
15. The NCP has specific treatment modalities/interventions aimed at resolving or reducing the severity of the identified nursing problems. Each tentative problem initiated by nursing on the tentative problem list has a NCP.
16. The RN documents in the progress notes when tentative problems are resolved and indicates the resolution on the tentative problem list.
17. NCPs are individualized and based on the patient's identified problems and appropriate interventions.

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Interventions

18. Treatment modalities/interventions address what the responsible staff will do, rationale, frequency, and responsible discipline.
19. Treatment modalities/interventions are realistic and stated in positive terms. Action words are used so that interventions are measurable.
20. Treatment Team Progress Notes are completed by RNs, LPNs, and HCTs. Each employee is responsible for documenting care and treatment as outlined in the NCP and Interdisciplinary Treatment Plan.
21. The RN documents implementation of interventions and the patient's response. Documentation is outcome based and specific to identifying progress made towards the goal(s).
22. Nursing Service Personnel (RN and HCT) document progress notes according to the Clinical Care Plan Policy VI-P-9 "*Progress Notes/Treatment Notes, Frequency and Content*".

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Evaluation

23. RNs evaluate treatment outcomes and document in the Treatment Team Progress Notes or the Active Treatment database.
24. Each intervention assigned to Nursing Service personnel is addressed in the Treatment Team Progress Notes.
25. Evaluations by the RN state whether or not there has been progress, regression, or no change regarding accomplishing the patient goals as outlined in the interdisciplinary treatment plan.

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25. Evaluations documented in the progress notes are considered during the revisions of the NCP and/or Interdisciplinary Treatment Plan.

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Related Policies:
CCP: VI-P-9 Progress Notes/Treatment Notes, Frequency and Content
CCP: VI-T-2 Transfer of Patients
CCP: VI-T-4 Treatment Planning

Section V N-1
Effective 7-07-2008
Supercedes 3-04

Subject: Nursing Process

Purpose: The Psychiatric-Mental Health Nurse collects patient health data, analyzes the assessment data in determining nursing diagnoses and develops a plan of care that prescribes interventions to attain expected outcomes. To provide a consistent format for Nursing Service Personnel to assess, plan, implement, and evaluate quality patient care.

Authority:
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DHSR Standards §.3804
21 NC Administrative Code 36.0224
21 NC Administrative Code 36.0225

Standard: The roles and responsibilities of Nursing Service staff are identified. The assessment, planning, documentation, and evaluation of patient outcomes are established and serve as a guide to Nursing Service Personnel.

Policy:

1. Nursing process shall be evident in the individual nurse's performance in the care and treatment of patients.
2. Registered Nurses (RNs) shall be accountable for assessing each individual patient's needs and for planning, implementing, and evaluating the treatment plan.
3. The RN shall assess all patients' status at the beginning of each shift. This process involves hand-off communication, ward report, and patient rounds during the shift.
4. There shall be a nursing component of each patient's interdisciplinary treatment plan. The plan shall include nursing strategies directed towards the treatment plan problems and goals. This component of the plan shall be monitored and evaluated by a RN with recommendations for changes documented on the treatment team progress notes and discussed with the treatment team.

Assessment

5. A pre-admission assessment will be completed in the admission's office prior to the patient going to the ward.

6. A nursing assessment shall be initiated by the admitting RN on each patient in all psychiatric admission units on the shift the patient is admitted. The nursing assessment shall be documented on

the Nursing Assessment form. In the event the nursing assessment cannot be completed within the admitting shift due to the patient's condition/refusal, the RN shall document such in the progress notes. The RN shall communicate via the ward written report and verbally to the on-coming RN the need to continue the assessment.

7. Upon transfer from one program/unit to another, or when the length of stay in another facility exceeds 24 hours, an assessment and review of the Nursing Care Plan(NCP)/Interdisciplinary Treatment Plan shall be completed within 24 hours of the transfer on the Nursing Assessment form.

8. Pain Assessment Screen (Refer to Pain Assessment, Nursing Service Policy).

9. The Health Care Technician (HCT) may assist in data collection during the assessment process and will document on the Nursing Assessment form.

10. The RN is responsible for immediately reviewing data collected by the HCT and no later than within one hour of arrival to ward. After reviewing, the RN will sign, date, and time beside the HCT's signature.

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Nursing Care Plan

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Interventions

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20. Nursing Service Personnel (RN and HCT) will document progress notes according to the Clinical Care Plan Policy: *Progress Notes/Treatment Notes, Frequency and Content.*

Evaluation

21. RNs shall evaluate treatment outcomes and document in the Treatment Team Progress Notes or the Active Treatment database.

22. Each intervention assigned to Nursing Service personnel will be addressed in the Treatment Team Progress Notes.

23. Evaluations by the RN shall state whether or not there has been progress, regression, or no change regarding accomplishing the patient goals as outlined in the interdisciplinary treatment plan.

24. Evaluations documented in the progress notes will be considered during the revisions of the NCP and/or Interdisciplinary Treatment Plan.

Related Policies:
CCP: VI-P-9 Progress Notes/Treatment Notes, Frequency and Content
CCP: VI-T-2 Transfer of Patients
CCP: VI-T-4 Treatment Planning

Cherry Hospital Nursing Services Policy Manual

Section IV – S-2
Effective 8/20/08
Supersedes 3/01/08

Subject: **Assignment of Nursing Staff**

Purpose:
To ensure safe patient care by accounting for the complexity and changing nature of individual patient needs; to ensure that Registered Nurses (RNs) plan, supervise, and evaluate the nursing care provided for each patient.

Authority: Nursing Practice Act §90-171.20. (7) and (8)
Joint Commission Standards
CMS Standards §482,23 (b)(5) & 482.23 (b)

Policy:
RNs assign, delegate, and coordinate each patient's nursing care by providing written staff assignments which are posted each shift. Staff assignments are posted in a manner in which patients can visualize the assignments and know who their assigned caregivers are. The assignment identifies staff members by name and title, each patient by name, and indicates specific aspects of nursing care or unit responsibilities to be performed by the staff member.

1. When making assignments, the RN considers the following:
   a. The patient's status, complexity of condition, and care;
   b. Equipment needed and competency level;
   c. The degree of supervision required by each nursing staff member;
   d. The availability of supervision;
   e. Relevant infection control and safety issues;
   f. Location of assigned patients in relation to each other;
   g. Workload equity;
   h. Continuity of nursing care;
   i. Rotation lists may be considered when making assignments, but the RN is responsible for making decisions regarding assignments based on patient care needs.

2. Each patient is assigned to an RN each shift. The assigned RN may choose to delegate aspects of the patient's nursing care to other nursing staff.

3. Assignments are made by the RN on the preceding shift and posted at the beginning of the next shift.

4. Nursing staff are accountable for the completion of assignments, which is reviewed at the end of each shift. Assignments include the expectation that RN rounds are made a minimum of 3 times per shift or more often as needed.

5. A nurse (RN or LPN) is assigned to monitor meal consumption during all meal times (including dining rooms and wards). The nurse is responsible for documentation of meal consumption on the Multipurpose Flowsheets.

6. The LPN (or RN assigned to medications) conducts regular rounds on the ward and informing the ward RN in charge of any changes in patients condition.

7. Health Care Technicians (HCTs) are assigned individual patients to perform and document personal care and other responsibilities. The HCT is responsible for alerting the ward RN of changes in the patients condition in a timely manner.

8. Any staff member who believes he/she cannot carry out their assignment alerts the charge nurse immediately.

9. All nursing staff members are evaluated by the ward RN for their ability to perform assignments and to safely provide care for patients.

10. All nursing staff assignment sheets are maintained in the unit for no less than two (2) years.

11. The unit Nurse Manager ensures that assignment sheets are filed chronologically and are easily accessible for future reference.

12. After two (2) years, the assignment sheets are sent to the warehouse for storage for at least five (5) additional years.

Attachments:
Assignment Sheets for day, evening, and night shifts

Cherry Hospital Nursing Services Policy Manual

Section IV – S-2
Effective 8/20/08
Supersedes 3/01/08

Subject: Assignment of Nursing Staff

Purpose:
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2. Each patient is assigned to an RN each shift. The assigned RN may choose to delegate aspects of the patient's nursing care to other nursing staff.

3. Assignments are made by the RN on the preceding shift and posted at the beginning of the next shift.

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• The complexity of the patient's condition and required nursing care (level of care, treatments, medications, potential for infection, emotional needs, educational needs and level of functioning).¶
• The dynamics of the patient's status, including the frequency with which the need ¶
for specific nursing care activities changes;¶
• The complexity of the care needs determined by assessment, including the ¶ knowledge and skills required of a nursing staff member in order to complete the ¶
required assignment;¶
• The type of technology employed for providing nursing care with consideration given to the knowledge and skills required to use the technology;¶
• The degree of supervision required by each nursing staff member based on his/her ¶
Previously assessed and current level of competence in relation to the nursing care needs of the patients;¶
• The availability of supervision;¶
• Relevant infection control and safety issues;¶
• Environment/unit geography (location of assigned patients in relation to each other);¶
• Workload equity;¶
• Shift lengths with special attentic ... [1]

4. Nursing staff are accountable for the completion of assignments, which is reviewed at the end of each shift. Assignments include the expectation that RN rounds are made a minimum of 3 times per shift or more often as needed.

5. A nurse (RN or LPN) is assigned to monitor meal consumption during all meal times (including dining rooms and wards). The nurse is responsible for documentation of meal consumption on the Multipurpose Flowsheets.

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7. Health Care Technicians (HCTs) are assigned individual patients to perform and document personal care and other responsibilities. The HCT is responsible for alerting the ward RN of changes in the patients condition in a timely manner.

8. Any staff member who believes he/she cannot carry out their assignment alerts the charge nurse immediately.

9. All nursing staff members are evaluated by the ward RN for their ability to perform assignments and to safely provide care for patients.

10. All nursing staff assignment sheets are maintained in the unit for no less than two (2) years.

11. The unit Nurse Manager ensures that assignment sheets are filed chronologically and are easily accessible for future reference.

12. After two (2) years, the assignment sheets are sent to the warehouse for storage for at least five (5) additional years.

Attachments:
Assignment Sheets for day, evening, and night shifts

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Cherry Hospital Nursing Services Policy Manual

Section IV – S-2
Effective 3-1-08
Supersedes June 15, 2007

Subject: Assignment of Nursing Staff

Purpose:
To ensure safe patient care by accounting for the complexity and changing nature of individual patient needs; to ensure that registered nurses plan, supervise, and evaluate the nursing care provided for each patient.

Authority: Nursing Practice Act §90-171.20. (7) and (8)
Joint Commission Standards
CMS Standards §482,23 (b)(5) & 482.23 (b)

Policy:
Registered nurses shall prescribe, delegate, and coordinate each patient's nursing care by providing written staff assignments which are posted each shift. Staff assignments must be posted in a manner in which patients can visualize the assignments and know who their assigned caregivers are. The assignment identifies staff members by name and title, each patient by name, and indicates specific aspects of nursing care or unit responsibilities to be performed by the staff member.

1. The Director of Nursing/Designee is responsible for the initial primary assignment of Nursing Staff to a specific home unit, ward, and shift. The shift/unit/ward assigned is primary, but staff may be required to work all shifts, weekends, holidays, during inclement weather, and overtime, and be assigned to another shift/unit/building based on the needs of the Hospital. This is an essential function of all Nursing Service positions. There are no permanent shifts or work assignments within the Nursing Department.

2. When making assignments, the RN considers the following:

- The complexity of the patient's condition and required nursing care (level of care, treatments, medications, potential for infection, emotional needs, educational needs and level of functioning).
- The dynamics of the patient's status, including the frequency with which the need for specific nursing care activities changes;
- The complexity of the care needs determined by assessment, including the knowledge and skills required of a nursing staff member in order to complete the required assignment;
- The type of technology employed for providing nursing care with consideration given to the knowledge and skills required to use the technology;

- The degree of supervision required by each nursing staff member based on his/her Previously assessed and current level of competence in relation to the nursing care needs of the patients;
- The availability of supervision;
- Relevant infection control and safety issues;
- Environment/unit geography (location of assigned patients in relation to each other);
- Workload equity;
- Shift lengths with special attention to maintenance of continuity of nursing care when staggered shift start times are in use;
- Rotation lists may be considered when making assignments, but in all cases, the RN is responsible for making decisions regarding assignments based on patient care needs.

3. Each patient is assigned to an RN each shift. The assigned RN may choose to delegate aspects of the patient's nursing care to other nursing staff.

4. Nursing staff members are accountable for the completion of their assignment, which is reviewed at the end of each shift. Assignments include the expectation that RN rounds shall be made frequently enough to maintain awareness of each patient's condition.

5. Any staff member who believes he/she can not carry out their assignment must alert the charge nurse immediately.

6. All nursing staff members are evaluated for their ability to meet basic clinical competencies and to safely provide care for patients with mental illness.

7. All nursing staff assignment sheets are to be maintained in the unit for no less than two (2) years.

8. The unit Nurse Manager shall ensure that assignment sheets are filed chronologically and are easily accessible for future reference.

9. After two (2) years the assignment sheets shall be sent to the warehouse for storage for at least five (5) additional years.

Attachments: Assignment Sheets for day, evening, and night shifts

CHERRY HOSPITAL
CLINICAL CARE PLAN

SUBJECT: Progress Notes/Treatment Notes, Frequency and Content

CCP Number: VI-P-9
Page: 1 of 6
Effective: 08/20/08
Supersedes: 07/22/08

PURPOSE: To establish guidelines regarding the frequency and content of progress notes and treatment notes entered into the patient record both on paper and electronically.

POLICY: Cherry Hospital is committed to providing quality psychiatric and medical treatment to its patients. Inherent in the provision of quality care is the need for quality documentation. To ensure quality documentation, all progress notes and treatment notes at Cherry Hospital are documented in a consistent standardized manner.

DEFINITIONS (for the purpose of this policy):

Progress notes are recordings in the medical record that are written by persons directly responsible for the care and active treatment of the patient. Progress notes give a chronological picture of how the patient is responding to treatment and progressing towards the accomplishment of their individual goals as described in their treatment plan. Progress notes are documented in the progress note section of the medical record or in the active treatment database.

Treatment interventions are the specific therapeutic actions of staff undertaken to assist the patient in meeting their short-term and long-term goals as designated by the treatment plan. Specific therapeutic interventions include (but are not limited to) drug therapy, individual therapy, family therapy, marital therapy, group therapy, art therapy, recreational therapy, and any specialized therapy ordered in the medical record.

Treatment notes are recordings in the medical record that indicate provision of, and a patient's response to a treatment intervention. Treatment notes are documented in the Active Treatment Database, on the Intervention Flow Sheet, in the Progress Notes section of the medical record, or in the Medication Administration Record.

A treatment note reflecting the patient's response to a specific treatment intervention may be incorporated into the content of a progress note summarizing how the patient has been progressing towards the accomplishment of their goals.

CHERRY HOSPITAL
CLINICAL CARE PLAN

SUBJECT: Progress Notes/Treatment Notes, Frequency and Content

CCP Number: VI-P-9
Page: 1 of 6
Effective: 08/20/08
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A treatment note reflecting the patient's response to a specific treatment intervention may be incorporated into the content of a progress note summarizing how the patient has been progressing towards the accomplishment of their goals.

PROCEDURE:

I. Progress Notes

Progress notes are documented by persons directly responsible for the care and active treatment of the patient (as per their discipline specifications).

A. Progress note frequency is determined by both the condition and the location of the patient.

Adult Admissions Unit, Adolescent Admissions Unit and Geriatric Admissions Unit

When the patient requires acute level of care ~~or has been in the hospital less than 60 days~~:

- Psychiatrist - 1 time every 7 days (including whenever there is a change in the patient's psychiatric condition as described in C below)
- Medical Physician/Physician Extender - whenever the patient has a medical problem warranting observation/medical intervention
- RN (except those RN's assigned groups) – every shift for three days, then every 3 days for as long as the patient remains at an acute level of care ~~(including whenever there is a significant change in the patient's condition). When the patient no longer requires an acute level of care (even if in the patient has been in the hospital less than 60 days), a progress note is required every 7 days.~~
- RN's assigned to groups – every fourteen days
- SW - within 3 days and then every 7 days
- All other disciplines providing active treatment as specified in the treatment plan – as determined by the relative department.

When the patient has been in the hospital less than 60 days:

- Psychiatrist – 1 time every 7 days (including whenever there is a change in the patient's psychiatric condition as described in C below)
- Medical Physician/Physician Extender – whenever the patient has a medical problem warranting observation/medical intervention
- SW – within 3 days and then every 7 days
- All other disciplines providing active treatment as specified in the treatment plan – as determined by the relative department.

When the patient requires non-acute level of care **and** has been in the hospital at least 60 days:

- Psychiatrist - 2 times every 30 days (including whenever there is a change in the patient's psychiatric condition as described in C below)
- Medical Physician/Physician Extender whenever the patient has a medical problem warranting observation/medical intervention
- RN (except those RN's assigned groups) ~~– 2 times every 30 days~~ every 7 days (including whenever there is a significant change in the patient's condition)
- RN's assigned to groups – every 30 days

- SW - every 30 days
- All other disciplines providing active treatment as specified in the treatment plan – as determined by the relative department

Psychosocial Rehabilitation Unit

When the patient requires acute level of care

- Psychiatrist - 1 time every 7 days (including whenever there is a change in the patient's psychiatric condition as described in C below)
- Medical Physician/Physician Extender - whenever the patient has a medical problem warranting observation/medical intervention
- RN (except those RN's assigned groups) every 3 days ~~(including whenever there is a significant change in the patient's condition)~~
- RN's assigned to groups – ever fourteen days
- SW - every 7 days
- All other disciplines providing active treatment as specified in the treatment plan – as determined by the relative department

When the patient requires non-acute level of care **and** has been in the hospital less than 60 days:

- Psychiatrist - 1 time every 7 days (including whenever there is a change in the patient's psychiatric condition as described in C below)
- Medical Physician/Physician Extender - whenever the patient has a medical problem warranting observation/medical intervention
- RN (except those RN's assigned groups) - every 7 days ~~(including whenever there is a significant change in the patient's condition)~~
- RN's assigned to groups – every 30 days
- SW - every 7 days
- All other disciplines providing active treatment as specified in the treatment plan - as determined by the relative department

When the patient requires non-acute level of care **and** has been in the hospital greater than 60 days:

- Psychiatrist - 2 times every 30 days (including whenever there is a change in the patient's psychiatric condition as described in C below)
- Medical Physician/Physician Extender - whenever the patient has a medical problem warranting observation/medical intervention
- RN (except those RN's assigned groups) – ~~2 times every 30 days (including whenever there is a significant change in the patient's condition)~~ every 7 days
- RN's assigned to groups – every 30 days
- SW - every 30 days
- All other providing active treatment as specified in the treatment plan – as determined by the relative department

Psychiatric Medical Unit (PMU)

When the patient requires PMU treatment due to an acute medical/physical need which cannot be managed in their home unit:

- Medical Physician/Physician Extender – every day including holidays and weekends
- Psychiatrist –1 time every 7 days (including whenever there is a change in the patient's psychiatric condition as described in C below)
- RN – every shift (including whenever there is a significant change in the patient's condition) (except those assigned to groups)
- RN's assigned to groups – every fourteen days if the patient is acute and every 30 days if the patient is non-acute
- SW – every 7 days
- All others providing active treatment as specified in the treatment plan – as determined by the relative department

For patients who remain in PMU after their medical acuity has resolved or those who are sent to PMU for non-medical/safety issues or overflow issues, frequency of progress note documentation by all disciplines follows the designated frequency in the patient's home unit. Patients in PMU for non-medical/safety issues or overflow issues are clearly identified by the Psychiatrist and/or the Medical Physician/Physician Extender in the progress notes and the Psychiatrist and/or Medical Physician/Physician Extender indicate why they remain in PMU.

Patients on More Than One Antipsychotic Medication

Patients on more than one antipsychotic medication have a Psychiatrist progress note addressing the rationale for the antipsychotic polypharmacy at least once a month.

Patients on Antipsychotic Medications Above the Total FDA Recommended Dosage

Patients on antipsychotic medications above the recommended total FDA dosage have a Psychiatrist progress note addressing the rationale for the dosage at least once per month.

Patients on Special Precautions

Patients on special precautions due to suicide or violence risk have an RN progress note and a HCT note completed each shift. See CCP VI-S-2a for further details.

B. Progress notes enable providers to plan and evaluate active treatment, enhance communication between professionals, assist with communication to third party participants, assist with development of quality improvement processes, provide legal documentation to verify delivery of care, and act as a source of clinical data for research and education. Progress note content includes a chronological picture of the patient's

course in the hospital and describes changes in the patient's condition as a result of active treatment interventions.

Psychiatric progress note content reflects:

- Pertinent facts about the individual's health and wellness
- Progress of the patient in meeting individualized treatment goals
- Staff efforts to help patient achieve stated goals through assigned interventions in the patient's individualized treatment plan
- Assessment of and changes in the patient's condition
- Changes in the treatment plan
- Family/significant other's response/input regarding the patient's care
- Patient's level of care. The patient's level of care shall be documented on admission and every 60 days thereafter for acute, non-acute, ICF, or criterion 5; or every 30 days thereafter for SNF.

The content of progress notes written by Nursing Staff, Social Workers, Psychologists, Rehab Therapists, and other disciplines contains at a minimum:

- Progress of the patient in meeting individualized treatment goals
- Staff efforts to help patient achieve stated goals through assigned interventions in the patient's individualized treatment plan
- Assessment of and changes in the patient's condition

C. Clinical triggers that necessitate a progress note by a Psychiatrist by the close of the next regular work day include:

- Medication changes (including one time orders but excluding orders for routine remedies of minor conditions)
- "STAT" or NOW orders for medications.
- Adverse drug reactions
- Use of seclusion and/or restraint (mandatory 1 hour assessment meets requirement)
- Initiation of 1:1 observation
- Ordered change (initiation or discontinuation) in suicide precautions
- Significant changes in patient's symptoms (such as incidents of aggression, improvement or exacerbation in psychosis, increase or decrease in anxiety, etcetera…)
- Changes in diagnosis
- Transfers between Cherry Hospital units

Notes written in response to clinical triggers are to be counted towards meeting the psychiatrist's required number of progress notes.

II. Treatment Notes

A. Treatment notes are documented each time a specific active treatment intervention is done.

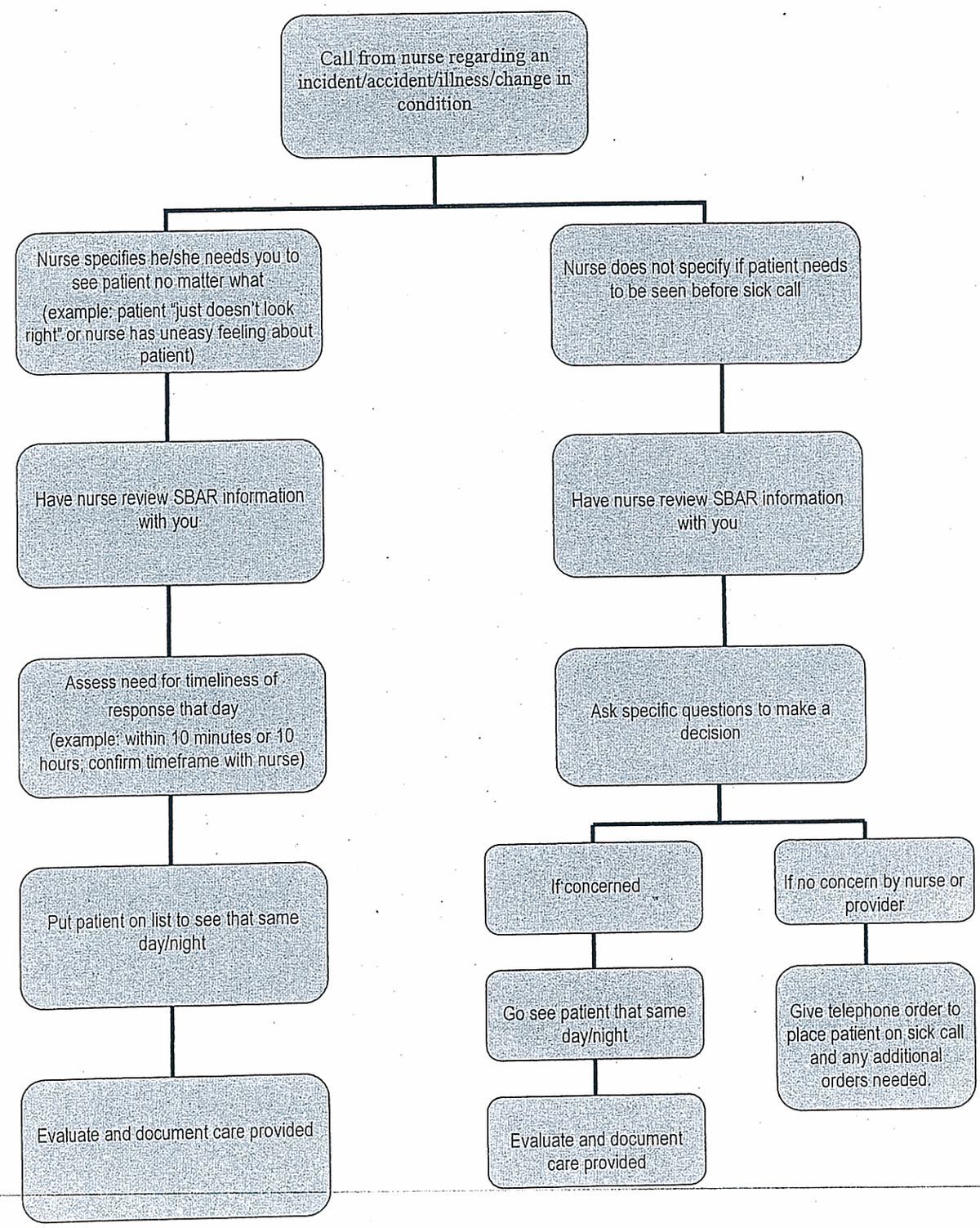
B. Treatment note content reflects:

- Provision of the treatment intervention
- The patient's response to the treatment intervention

References: APSR 110-11; APSR 110-8

Effective: 8/20/08
Supersedes: 07/22/08
11/26/07
07/01/07

Decision Tree for Incident/Accident/Illness/Change in Condition



srw: 8/19/08